| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345489 | A. BUILDING _____ B. WING _____ | C 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SATURN NURSING AND REHABILITATION CENTER | 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>A follow up and complaint investigation survey was conducted from 10/28/21 through 11/10/21. Event ID# N6RD11 and B5B913. Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F686 at a scope and severity K<br>CFR 483.35 at tag F725 at a scope and severity K<br><br>The tag F686 constituted Substandard Quality of Care. A partial extended survey was conducted.<br><br>4 of the 30 complaint allegations were substantiated but did not result in a deficiency.<br><br>18 of the 30 complaint allegations were substantiated resulting in deficiencies.<br><br>8 of the 30 complaint allegations were not substantiated. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's | F 550 | | 12/10/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/02/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 550 | Continued From page 1<br>individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview of resident and staff, the facility failed to feed a resident when her meal tray was placed on her bedside table. The resident was left to observe her tray but not able to access the meal while staff fed another resident for approximately 20 minutes (Resident #11) and staff stood up over a resident while feeding him (Resident #6) for 2 of 3 residents sampled.<br>Findings included: | F 550 | F-550 Resident Rights/Exercise Rights<br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #11 and Resident #6 are now receiving their meals by the staff, in a manner to ensure the meal tray is not left in room until staff is able to aid with meals, and staff will be using a chair to | |

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| F 550 | Continued From page 2<br><br>1. Resident #11 was admitted to the facility on 6/24/21 with diagnosis of muscle weakness.<br><br>Resident #11 ' s quarterly Minimum Data Set dated 8/10/21 documented unclear speech, sometimes understood, usually understands. The resident was dependent for activities of daily living.<br><br>On 10/29/21 at 12:20 an observation was done of Nursing Assistant (NA) #5 place Resident #11 ' s meal tray on her bedside table within her view. The tray was in the resident ' s room for approximately 20 minutes while NA #5 feed another resident across the hall.<br><br>On 10/29/21 at 12:20 pm an interview was conducted NA #5. NA #5 stated she was not aware that she should not leave a meal tray in a resident ' s room when not ready to feed; it was a dignity issue.<br><br>On 10/29/21 at 12:40 pm an interview was conducted with Medication Aid #1. She was assigned to resident #6 and stated that the NAs should not leave a meal tray in front of the resident who was dependent until the NA was ready to feed. She stated she would speak to NA #5.<br><br>2. Resident #6 was admitted to the facility on 1/21/21 with the diagnosis of muscle weakness.<br><br>Resident #6 ' s care plan last updated on 9/21/21 documented that he was dependent for all activities of daily living.<br><br>Resident #6 ' s quarterly Minimum Data Set dated | F 550 | provide meal assistance at eye level and encouraging interaction with resident during meal assistance, as of 11/4/21.<br>NA #5 received 1:1 re-education by Regional Clinical Nurse (RCN) on 11/04/2021 on Resident Rights, the resident rights including, proper assistance for dependent residents, who need assistance with meals, including sitting at eye level while feeding and ensuring trays are not left in front of a dependent resident until meal assistance can be provided by staff.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Director of Nursing and/or unit managers completed observation rounds to ensure that current residents were receiving meal assistance properly, on 10/30/21.<br>Any resident identified needing assistance with meals will receive their meal tray when staff member is ready to set tray up and able to sit down and feed resident one on one at eye level.<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br>All nursing staff, including agency was re-educated by Regional Clinical Nurse on 11/11/2021, on Resident Rights, related to proper assistance for dependent residents, who need assistance with meals, including sitting at eye level while feeding and ensuring trays are not left in front of a dependent resident until | |

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| F 550 | Continued From page 3<br>10/23/21 documented an intact cognition, dependent for activities of daily living, and active diagnosis of muscle weakness.<br><br>On 10/29/21 at 12:20 pm an observation was done of Resident #6. The resident was in his bed and NA #5 was standing at the bedside feeding him. The tray table was lateral to the bed and the NA had to reach over the bed to reach the resident. NA #5 was not conversing with the resident during feeding and had limited eye contact.<br><br>On 10/29/21 at 12:20 pm an interview was conducted NA #5. She stated that sometimes she stood to feed a resident. She also stated that the bed was up and there was no chair in the room, it was easier to feed standing. NA #5 stated she would obtain a chair and sit to feed the resident.<br><br>On 10/29/21 at 12:40 pm an interview was conducted with Medication Aid #1. She was assigned to resident #6 and stated that the NAs were required to sit while feeding a resident and would speak to NA #5. | F 550 | assistance is provided. Any staff not attending the in-service by, 12/10/2021, will not be allowed to work until the re-education is completed.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing and Unit Managers will observe 5 residents daily for 5 days per week times 3 weeks, then 3 times per week for 4 weeks to ensure that staff is providing proper meal assistance for those resident's requiring assistance with meals. Any deficiencies noted will be addressed immediately and corrective action taken as necessary, which may include disciplinary action. Results will be recorded on an audit tool titled "Dining Observation" and presented by the Director of Nursing to the Quality Assurance Performance Improvement Committee meetings monthly x 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>Completion date: 12/10/2021. | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. | F 558 | | 12/10/21 |

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| F 558 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview of resident and staff, the facility failed to provide a call light to meet a dependent resident ' s (Residents #6 and 11) accommodation for 2 of 3 residents sampled.<br><br>Findings included:<br><br>1. Resident #6 was admitted to the facility on with the diagnosis of muscle weakness<br><br>Resident #6 ' s quarterly Minimum Data Set (MDS) documented that the resident had an intact cognition. The resident required extensive assistance with all activities of daily living.<br><br>Care plan documented for Resident #6 last updated on 9/1/21 revealed the resident required assistance with all his activities of daily living (was dependent).<br><br>On 10/28/21 at 10:40 am an observation was done of Resident #6 in his bed. He had no use of his lower extremities and gross use of his arms and hands with no use of the fingers (able to bend). The resident had no call light in the room.<br><br>On 10/28/21 at 10:40 am an interview was conducted with Resident #6. The resident stated he had no call light because he could not press the button. The resident had to "holler" (call out) for help and the staff could not always hear him. The resident stated it would take a long time to get help and that was a problem when he was in pain (resident had painful pressure ulcers).<br><br>On 10/29/21 at 7:00 am an interview was | F 558 | F558 – Reasonable Accommodations Needs/Preferences<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>The Director of Nursing and Rehabilitation Director completed an assessment for Resident #6 and #11, for a paddle call bell, the appropriate call bell was provided 10/29/2021.<br>MA #1, NA#3, received reeducation from Regional Nurse Consultant, related to “Reasonable Accommodations for resident(s) needs/preferences, including ensuring the resident can push or touch the call bell allowing independence to call for assistance by resident. This training was completed on 11/4/21.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Rehabilitation director completed an audit, on 11/11/2021 of current residents to identify any resident, who would need a touch pad call light, no other resident was identified in need of a paddle call bell. Current residents have a call bell based on their ability to allow for them to call for assistance, as of 11/11/21<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: | |

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| F 558 | Continued From page 5<br>conducted with Nursing Assistant (NA) #3 (night shift). NA #3 stated Resident #6 could call out for assistance.<br><br>On 10/29/21 at 7:55 am an interview was conducted with Medication Aid #1. MA #1 stated she was familiar with and assigned to Resident #6. The resident was able to make his needs known and would call staff for assistance. She was aware the resident had no call light due to his inability to press the button.<br><br>On 10/29/21 at 10:30 am an observation was done of Resident #6 in his bed. There was a touch pad call light sitting on the resident ' s chest. The resident commented, "they gave this to me today, and I can press it."<br><br>On 11/3/21 at 12:30 pm an interview was conducted with the Director of Nursing (DON) and corporate nurse consultant (CNC). The CNC stated that staff was aware of Resident #6 ' s inability to press a call light and a touch pad call device was placed on 10/29/21. The CNC stated that other dependent residents would be evaluated whether a touch pad call device would be a good option.<br><br>2. Resident #11 was admitted to the facility on 6/24/21 with diagnosis of anoxic brain damage.<br><br>Resident #11 ' s quarterly MDS dated 8/10/21 documented unclear speech, sometimes understood, usually understands. She had a moderately impaired cognition and was dependent for activities of daily living. Active diagnosis was anoxic brain damage.<br><br>Resident #11 ' s updated care plan dated 7/11/21 | F 558 | At the time of admission, re-admission, or a decline of resident condition, there will be an assessment completed, by licensed nurse and/or Rehabilitation Director, to identify proper call light to ensure independence of the resident to request assistance of needs/preferences.<br>The Executive Director, DON, and Corporate Nurse Consultant will complete retraining with facility nursing staff, including agency/contract, on resident rights, including “Accommodation of Resident Needs/Preferences” by 12/10/2021.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.<br>The Director of Nursing and/or designee will observe delivery of care and interaction of staff with at least 5 residents during facility rounds daily times 5 days times 4 weeks, then 3 days per week x 4 weeks. Results of these audits will be recorded on an audit tool, “Observation of Call Light Utilization” and presented by the Director of Nursing and/or Executive Director to the Quality Assurance Performance Improvement Committee meetings monthly x 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>Completion date: 12/10/2021 | |

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| F 558 | Continued From page 6<br>documented the resident was dependent for all activities of daily living.<br>On 10/28/21 at 10:40 am the resident was observed to be calling staff. The resident was lying in her bed and her neck was bent to the right off the pillow and was unable to reposition. The resident had gross movement of her arms and hands and spastic movement of her legs.<br><br>Observation of the resident revealed the staff had not responded to the resident ' s verbal call for approximately 15 minutes. There was no call light in the room. The assigned staff MA #1 was retrieved to assist the resident.<br><br>On 10/28/21 at 10:40 am an interview was attempted with Resident #11. She had garbled speech but was able to turn her head toward the pillow and struggle to move back on to the pillow unsuccessfully.<br><br>On 10/28/21 at 10:55 am an interview was conducted with MA #1. She stated that the resident had spastic muscles and had to be moved in the bed frequently. The resident was able to understand you, was checked periodically, and could make her needs known.<br><br>On 11/3/21 at 12:30 pm an interview was conducted with the Director of Nursing (DON) and corporate nurse consultant (CNC). The CNC stated that staff was aware of Resident #6 ' s inability to press a call light and other dependent residents (including Resident #11) would be evaluated whether a touch pad call device would be a good option. | F 558 | | |
| F 580 SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15) | F 580 | | 12/10/21 |

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| F 580 | Continued From page 7 | F 580 | | |

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

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| F 580 | Continued From page 8<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with the staff and Medical Doctor (MD) the facility failed to notify the MD when significant medications were omitted on 2 separate occasions (Resident #12, #13, and #14) and failed to the notify the MD when treatments were not provided as ordered (Resident #6 and #15) for 5 of 5 residents reviewed for notification.<br><br>The findings included:<br><br>1. Resident #14 was admitted to the facility on 2/10/21 with diagnoses of hypertension and chronic diastolic heart failure.<br><br>Review of the physician order written on 10/6/21 revealed Resident #14 was to receive diltiazem 120 milligrams daily for hypertension.<br><br>Review of a significant change Minimum Data Set (MDS) dated 10/10/21 assessed Resident #14's cognition as moderately impaired and required extensive assistance with bed mobility, transfers, | F 580 | F-580 PHYSICIAN NOTIFICATION<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Director of Nursing and Corporate Nurse Consultant completed a review of the medical record for Resident #12, #13, #14, #6, and #15, to ensure no negative outcomes due to missed medication and/or treatments. The attending physician for these residents were notified by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continued current medication and/or treatments as ordered, and no new orders were obtained Residents #12, 13, 14, 6 and 15 have been receiving their medications and/or treatments as ordered by their attending physician as of 12/10/21.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: | |

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| F 580 | Continued From page 9<br>and toilet use. The MDS medication review revealed diuretic and opioid medications were received 3 days during the assessment look back period.<br><br>The care plan last revised on 10/12/21 identified cardiovascular disease diagnoses as atrial fibrillation, congestive heart failure, and hypertension with the goal for Resident #14 not experience complications through the next review. Interventions included administer cardiac medications as ordered.<br><br>A review of Resident #14's MAR for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented under the administration of diltiazem 120 milligrams scheduled at 8:00 AM.<br><br>2. Resident #12 was admitted to the facility on 3/13/21 with a diagnoses of type 2 diabetes mellitus and dementia.<br><br>Review of the quarterly MDS dated 8/20/21 assessed Resident #12's cognition as being severely impaired and required total assistance with bed mobility, transfers, and toilet use and limited assistance with eating. The MDS medication review revealed insulin injections were given 7 days during the assessment look back period.<br><br>The care plan last revised on 5/9/21 identified | F 580 | RCN completed a review of current resident medication/treatment administration records, for the past 30 days, on 12/10/2021, to identify medication and/or treatment omissions. Any identified omissions, the attending physician for those residents were notified, by the Director of Nursing and/or Regional Clinical Nurse. This audit will be completed by 12/10/21. Current residents are receiving their medications as of 12/10/21<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>The director of nursing and/or unit managers will be reviewing current resident medication/treatment records, for previous 24 hours to ensure to ensure that residents are receiving their medication/treatments as ordered by their attending physician. If there are any noted omissions, the licensed nurse will be contacted for re-education, verification that medication/treatment was administered, and completion of documentation.<br>Director of Nursing and/or Regional Clinical Nurse completed re-education with licensed nurses, medication aides, including agency, related to timely documentation of medication/treatment administration records. This included, notification of the Medical Director, Director of Nursing and Executive Director if medication or treatments were not | |

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| F 580 | Continued From page 10<br>diabetes mellitus and uncontrolled blood sugar levels with the goal Resident #12 would have an A1C (a percentage of blood glucose readings over a period of 3 months) be below 6. Interventions included administer hypoglycemic agents and obtain blood sugar as ordered.<br><br>Review of physician orders for insulin revealed Resident #12 was to receive aspart subcutaneously per sliding scale started on 3/24/21 and detemir inject 30 units subcutaneously every morning started on 6/24/21 for the diagnosis of diabetes mellitus.<br><br>A review of Resident #12's Medication Administration Record (MAR) for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented for the times of 7:30 AM and 11:30 AM under the administration of sliding scale aspart insulin (a fast-acting antidiabetic medication) with no blood glucose readings documented. The letter N was documented under the administration of detemir insulin (a long-acting antidiabetic medication) inject 30 units subcutaneously scheduled at 8:00 AM.<br><br>3. Resident #13 was admitted to the facility on 4/9/19 with diagnoses of type 2 diabetes mellitus and chronic obstruction pulmonary disease.<br><br>Review of physician orders for insulin revealed Resident #13 was to receive aspart 25 units subcutaneously before meals started on 6/29/21 and detemir inject 30 units subcutaneously twice | F 580 | completed timely. Any licensed nurse, including agency who has not received this education by 12/10/21, they will not be able to work until education completed.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.<br><br>The Director of Nursing/designee will audit all medication/treatment records 5 times/ week for 4 weeks, then 3 times/ week for 4 weeks. The Nurse Consultant will audit at least 5 records each month for 3 months. Results of these audits will be recorded on an audit tool titled Physician notification Medication Audit.<br><br>Director of Nursing and/or unit manager will complete a summary of audit results, that will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings times 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continual compliance.<br><br># 5 - Completion date: 12/10/21 | |

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a day started on 5/27/21 for diabetes mellitus.

Review of the quarterly MDS dated 8/24/21 assessed Resident #13's cognition as being intact and extensive assist was needed with bed mobility, transfers, and toilet use. The medication review of the MDS revealed insulin injections were administered for 7 days during the assessment look back period.

The care plan last reviewed on 9/6/21 identified diabetes mellitus with the goal Resident #13 would not experience hypo and/or hyperglycemia through the next review. Interventions included administer insulin as ordered.

A review of Resident #13's MAR for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented under the administration of fast-acting insulin aspart inject 25 units scheduled at 7:30 AM and 11:30 AM. The letter N was documented under the long-acting insulin detemir inject 30 units scheduled at 8:00 AM.

An interview was conducted on 10/29/21 at 4:06 PM with Nurse #1. Nurse #1 revealed on 10/10/21 and 10/24/21 she worked on a unit that typically two nurses were assigned to cover and was the only nurse until approximately 3 to 4 PM on both days. Nurse #1 stated she did not think to call the MD and notify him residents had missed their medications and stated she was struggling to complete her task and felt overwhelmed with the assignment.

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During an interview on 10/29/21 at 4:30 PM the Director of Nursing (DON) revealed she was unaware residents did not receive all their scheduled medications on 10/10/21 or 10/24/21 due to insufficient nurse staff for an assignment. The DON revealed she was aware on 10/24/21 there was not a nurse to cover the second assignment and kept in contact with Nurse #1 to relay a message the second shift nurse was coming in early. The DON stated with the number of residents on that unit she would not expect one nurse could complete a 2-nurse assignment and successfully administer residents all their medication.

An interview on 11/4/21 at 10:32 AM was conducted with the MD. The MD stated that when the residents missed medications there could be harm for critical medications that were missed. If insulin was not given and the blood glucose was not checked for the ordered sliding scale that would cause harm. The MD stated that staff on later shifts should have seen that medication was not given and tried to give the daily dose of medication. The MD stated he expected the nurse to report the missed medications to him or the Nurse Practitioner and that was not done, and he was not informed there were a lot of errors related to missed medications.

Findings included:

4. Resident #6 was admitted to the facility on 1/21/21 with muscle weakness and pressure

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ulcers to his right and left ischium and sacrum.

Resident #6 ' s quarterly Minimum Data Set (MDS) dated 10/12/21 documented an intact cognition and active diagnosis of pressure ulcer.

A review of Resident #6 ' s treatment administration record (TAR) for October 2021 orders for daily wound care treatments. The TAR revealed the following:

· Right toes care was not documented as provided on 10/1/21 - 10/4/21 and 10/6/21 - 10/10/21
· Left elbow care was not documented as provided on 10/20/21 - 10/25/21 and 10/29
· Right 5th toe (start 10/18/21) care was not documented as provided on 10/20/21 - 10/25/21 and 10/29
· Right ischium care was not documented as provided on 10/1/21 - 10/4/21, 10/6/21 - 10/10/21, 10/20/21 - 10/25/21, and 10/29/21
· Left ischium care was not documented as provided on 10/1/21 - 10/4/21, 10/6/21 - 10/10/21, 10/20/21 - 10/25/21, and 10/29/21
· Sacrum care was not documented as provided on 10/6/21 - 10/10/21, 10/20/21 - 10/25/21, and 10/29/21

The care was not documented as provided on the TAR.

On 10/28/21 at 5:25 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned on 10/10/21 and 10/24/21 to cover 2 assignments and was unable to complete wound care due to a lack of staffing. The TAR for Resident #6 was not initialed because the care was not done. Nurse #1 stated that she informed

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the Director of Nursing (DON) on both occasions. Nurse #1 stated she had not informed the physician.

On 11/5/21 at 3:00 pm an interview was conducted with Nurse #9. Nurse #9 stated that the failure to provide wound care was discussed in the morning stand up meeting (daily clinical meeting where management was present).

On 11/4/21 at 2:10 pm an interview was conducted with the Director of Nursing (DON) and corporate nurse consultant. Both staff stated after a review of Resident #6 ' s TAR documentation for October 2021, if there were no nursing staff initials documented, the care was not completed due to insufficient staffing. The DON stated she was made aware by Nurse #1 and Nurse #9 that wound care was not completed as ordered.

On 11/4/21 at 11:10 am an interview was conducted with the facility physician. He stated that he was not made aware that Resident #6 ' s wound care was not completed as ordered. He stated if informed, he would have assessed the wounds.

5. Resident #15 was admitted to the facility on 5/2/18 with the diagnosis of muscle weakness.

Resident #15 ' s quarterly Minimum Data Set (MDS) dated 8/8/21 documented an intact cognition. Pressure ulcer was not coded.

Resident #15 ' s treatment administration record (TAR) for September and October 2021 included an order for wound care to his right buttock wound daily. The TAR revealed:

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· Right buttock care was not documented as provided on 9/22/21 - 9/26/21, 10/1/21 - 10/6/21, 10/11/21 pm - 10/15/21, 10/17/21 - 10/28/21, 10/20/21 - 10/22/21, 10/23/21 pm, 10/28/21 pm, and 10/30/21 am

On 10/28/21 at 5:25 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned on 10/10/21 and 10/24/21 to cover 2 assignments and was unable to complete wound care due to a lack of staffing. The TAR for Resident #15 was not initialed because the care was not done. Nurse #1 stated that she informed the Director of Nursing (DON) on both occasions. Nurse #1 stated that a lack of staffing that affected the ability to provide care was an ongoing problem and management was aware that care was not being completed. Nurse #1 was aware that 10/10/21 and 10/24/21 were not the only days in October 2021 that had insufficient staff and care was not completed as reflected in the blank TAR documentation. Nurse #1 stated she had not informed the physician.

On 11/4/21 at 2:10 pm an reinterview was conducted with the Director of Nursing (DON) and corporate nurse consultant. Both staff stated after a review of Resident #15 ' s TAR documentation for September and October 2021, if there were no nursing staff initials documented, the care was not completed due to insufficient staffing. The DON stated she was made aware by Nurse #1 and Nurse #9 that wound care was not completed as ordered.

On 11/4/21 at 11:10 am an interview was conducted with the facility physician. He stated that he was not made aware that Resident #15 ' s

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| F 580 | Continued From page 16<br>wound care was not completed as ordered. He stated if informed, he would have assessed the wounds. | F 580 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview of resident and staff, the facility failed to provide hair wash and nail care to a dependent resident (Resident #6) for 1 of 3 residents sampled.<br><br>Findings included:<br><br>Resident #6 was admitted to the facility on 1/21/21 with the diagnosis of muscle weakness.<br><br>Resident #6 ' s care plan last updated on 9/21/21 documented that he was dependent for all activities of daily living.<br><br>Resident #6 ' s quarterly Minimum Data Set dated 10/23/21 documented an intact cognition, dependent for activities of daily living, and active diagnosis of multiple muscle weakness.<br><br>A review of Resident #6 ' s shower/bathing sheets provided by the facility for the month of October 2021 revealed he had a bed bath on 10/6/21, 10/20/21, 10/23/21, and 10/27/21. Hair care was documented as provided on 10/6/21 and 10/21/21. Nail care was documented as provided | F 677 | F 677 - ADL Care Provided for Dependent Residents:<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #6 was given a shower, hair was washed, and nails cleaned on 11/05/2021, by assigned certified nursing assistant (CNA). During an interview with Director of Nursing the resident did state that he preferred to keep his nails long and after his hair is washed he requests that grease be placed on his scalp. These preferences have been added to his care plan.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Director of Nursing and unit managers completed observation rounds to identify any other residents who requested ADL care, including shower, nail trimming, or hair washed. Any identified residents, did | 12/10/21 |

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| F 677 | Continued From page 17<br>on 10/6/21 and 10/23/21.<br><br>On 10/28/21 at 10:40 am an interview was conducted with Resident #6. The resident stated that his hair had not been washed in a long time. The resident could not remember when. The resident stated that he would like to have his hair washed and nails cut. The resident stated the "staff had not offered to cut my nails."<br><br>On 10/28/21 at 10:40 am an observation was done of Resident #6 while in his bed. The resident ' s hair appeared greasy and segmented. The resident had limited use of his hands and his right hand was held closed. The nails were noted to be long and pressed into his palm. Skin was intact.<br><br>On 10/29/21 at 7:00 am an interview was conducted with Nursing Assistant (NA) #3. The NA stated the nursing assistants were responsible to cut the resident ' s nails if they were not a diabetic. The NA agreed that Resident #6 ' s nails were quite long. Observation was done of the NA wash and cut Resident #6 ' s nails with the assistance of assigned Nurse #6. The NA stated that residents get their hair washed when they have a shower. Since Resident #6 was bed bound and had wounds, he would need to have his hair washed in the bed. The NA stated she was not sure when Resident #6 had his hair washed last.<br><br>On 11/4/21 at 11:30 am an observation and interview were done of Resident #6 in his bed. His hair remained unchanged with a greasy appearance that was segmented. The resident stated he had not had his hair washed. | F 677 | receive a shower, nails trimmed, and hair washed by their assigned CNA, on 11/11/21<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Rehab aide completed a interview with current residents, on 11/30/21, to determine preference of their bathing, and ADL care, including, bathing, nail care, and washing of hair. The director of nursing and unit manager completed a new shower schedule based on the current resident preferences and this was implemented 12/10/21.<br>Nursing staff, including agency was re-educated on the new shower schedule, including the importance of providing ADL care based on resident preference. Any newly hired nursing staff, including agency, will receive this training during orientation. Nursing staff who did not receive this education by 12/10/21, will not be allowed to work, until re-education is completed.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed.<br>The Director of Nursing or designee will audit shower documentation sheets, five times per week x 4 weeks then three times a week x 4 weeks.<br>A summary of these audits will be completed by the director of nursing or | |

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| F 677 | Continued From page 18<br>On 11/4/21 at 2:10 pm an interview was conducted with the Director of Nursing (DON) and corporate nurse consultant. Both staff stated they were made aware that care was not completed due to insufficient staffing. The DON was made aware that hair and nail care were not completed for Resident #6 and agreed care should be done. | F 677 | designee and results will be reviewed and discussed in the monthly Quality Assurance Improvement Committee meeting times 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continual compliance.<br><br># 5 - Completion date: 12/10/2021 | |
| F 686 SS=K | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews with resident, staff, guardian, Wound Family Nurse Practitioner and physician, the facility failed to: assess and document wounds consistently; provide wound treatments as ordered; and provide pressure relief from equipment that operated in accordance with manufacturer ' s instructions. These failures led to the development of new wounds, wounds that worsened in size and became infected (#6 and | F 686 | # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #6 was readmitted with diagnosis: chronic osteomyelitis, epilepsy, urinary retention, and pressure ulcer. TARS reveal scattered missing wound treatments during the last month. He was discharged to the hospital on 10/11/21 for | 12/10/21 |

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| F 686 | Continued From page 19<br>#15), and wounds that resulted in hospital interventions. These problems affected 2 of 3 sampled residents with pressure ulcers. Resident #6 developed a new pressure ulcer on the elbow, developed larger wounds on the hips and sacrum that became infected, acquired osteomyelitis of the toe and expressed pain from inadequate pressure relief while in bed. Resident #6 required hospitalization for treatment of the osteomyelitis with intravenous antibiotics. Resident #15 developed a new wound that advanced to the highest stage with infection. This resulted in surgical debridement and hospital treatment.<br><br>Immediate jeopardy began on 9/22/21 for Resident #15 when the facility failed to provide ongoing assessment for skin abrasion of his buttock which resulted in a black necrotic unstageable pressure ulcer the size of a fist that required surgical debridement. Immediate jeopardy began on 10/11/21 for Resident #6 when his right toe unstageable ulcer required debridement and antibiotics. Immediate jeopardy was removed on 11/7/2021 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service.<br><br>Findings included:<br><br>1. Resident #6 was admitted to the facility on 1/22/21 with muscle weakness and pressure ulcers to his right and left ischium and sacrum. | F 686 | treatment of a declining wound and readmitted on 10/18/2021. On 10/29/2021, it was noted that his air mattress had malfunctioned, and it was replaced. Resident # 6 was assessed for current wounds and treatments on 11/5/2021 by wound nurse practitioner, treatment nurse and nurse consultant. Treatment orders are to continue, at this time, after reevaluation. Air mattress is functioning properly and checked every shift for continued function and resident is noted to be comfortable during wound evaluation.<br><br>Resident #15 was originally admitted on 05/02/2018 with diagnosis: multiple sclerosis, failure to thrive, and pressure ulcer. Wound was noted on 9/22/2021 to extend to the right ischial area with identification of the right buttock which is noted in the residents' wound records as a Stage 4. Resident was transferred to the hospital for left sided facial drooping and increased aphasia while participating in therapy. During hospitalization it was noted that resident's wound had necrotic eschar and wound was debrided during this hospitalization. Resident was readmitted on 10/28/2021 with new orders for wound which were initiated. Resident was seen by in-house treatment nurse and wound nurse practitioner on 11/05/2021, to ensure wound measurements, current treatment orders are appropriate to promote healing. Resident was comfortable and had no pain with treatment provided. Air mattress initiated and functioning properly on | |

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| F 686 | Continued From page 20<br>Resident #6 ' s admission Minimum Daily Set (MDS) dated 2/1/21 documented he had an intact cognition. He had bowel incontinence. He had one stage 4 pressure ulcer and 6 unstageable pressure ulcers with suspected deep tissue injury.<br><br>Resident #6 ' s quarterly MDS dated 5/10/21 documented he had 2 stage 3 pressure ulcers, 3 stage 4 pressure ulcers, and 3 unstageable pressure ulcers with suspected deep tissue injury. He had bowel incontinence.<br><br>Resident #6 ' s physician order dated 6/19/21 right toes paint area with betadine daily for deep tissue injury.<br><br>Resident #6 ' s physician order dated 7/12/21 for the right ischium was to clean with wound cleanser daily and pat dry. Pack with wet Dakin ' s 0/5% solution gauze and cover with dry sterile dressing (DSD).<br><br>Resident #6 ' s physician order dated 7/12/21documented left ischium clean with wound cleanser daily and pat dry. Pack with wet Dakin ' s solution gauze and cover with dry sterile dressing (DSD). Resident #6 ' s physician order dated 7/12/21 for the sacrum was to clean with wound cleanser daily and pat dry. Pack with wet Dakin ' s solution gauze and cover with DSD.<br><br>Resident #6 ' s care plan last updated for pressure ulcers on 9/21/21 documented that he had pressure ulcers to his left heel, right toes, left elbow, bilateral ischium, and sacrum. The right toes all had black necrotic tissue, unstageable, and scabbed (stable). Interventions for pressure ulcers were pressure reduction device and turning. | F 686 | 11/06/2021.<br><br># 2 - Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>The Facility has employed a Full-Time wound Nurse for the facility 11/5/2021. New would care provider is now in place as of 11/5/2021. The Corporate Clinical Nurse completed a Competency with the facility wound nurse and Director of Nursing to ensure they were competent in wound identification, measuring, treatments and healing.<br>The Director of Nursing and Administrative Nurses completed a Head-to- toe assessment of current residents on 11/04/2021, to evaluate current skin condition and identify any new skin deficiencies. Any areas identified were cross referenced with resident's Treatment Administration Record to ensure treatments were in place and being implemented timely. Any new areas that would have been identified the resident's attending physician would have been notified and treatment order obtained. There were no new areas noted.<br>11/4/2021, Regional Clinical Nurse completed a review of nurse's notes, for the last 30 days. No new concerns were noted. This included, an audit of the previous weeks' wound progress notes, reviewed for current wound orders and were updated as applicable. This also included updating resident care plans and care guides to ensure interventions for each resident to prevent and treat | |

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| F 686 | Continued From page 21<br><br>Resident #6 ' s pressure ulcer reduction bed was to enhance healing and prevent skin breakdown. The manufacturer instructions indicated close supervision was needed when used by a person with disability. The mattress inflation level was according to the person ' s weight and comfort level in conjunction with the physician. The manufacturer ' s comfort and weight level table provided the inflation recommendation by the person ' s weight. Service and malfunction will light for malfunction of the mattress. Warning: the pump unit should always be operating to prevent bedsores from occurring.<br><br>The wound care family nurse practitioner progress note dated 9/9/21 documented Resident #6 ' s wound to sacrum was stage 4 and had length 6 centimeters (cm), width 3 cm, and depth 2 cm. There was no tunneling (opening under the skin in one direction) and there was moderate serosanguinous drainage and undermining (opening under the skin in more than one direction) at 9 o ' clock of 1.1 cm. The wound to his left ischium was stage 4 had length 3 cm, width 2.1 cm, and depth 1.2 cm. There was yellow necrotic tissue with minimal serosanguinous drainage. The wound to his right ischium was stage 4 had length 3.8 cm, width cm 1.5, and depth 1 cm. There was yellow necrotic tissue. There was no tunnel for either ischium pressure ulcer but slight odor. The ischium and sacral ulcers had improved. Right toes all had black necrotic tissue, were unstageable, and scabbed.<br><br>The wound care family nurse practitioner progress note dated 9/20/21 documented Resident #6 ' s left elbow was an unstageable | F 686 | pressure ulcers.<br><br># 3 - Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>The facility wound care nurse and/or designee will be providing weekly rounds for any residents identified with an identified wound, to evaluate status, including measuring, treatments, and healing. Any newly identified resident with a wound, the wound care nurse will notify the resident attending physician to ensure appropriate treatment is implemented, timely. At the time of new resident admission, the facility licensed nurse is required to complete a body assessment to identify resident skin integrity and any identified concerns, will be discussed with the attending physician for an immediate intervention, treatment order to promote healing.<br>On 11/4/2021, all residents with air mattresses were observed for functioning equipment by the director of nursing and administrative nurses. Orders were added to check function every shift by licensed nurse, and documented on the resident's electronic treatment administration record (TAR).<br><br>Director of Nursing, unit managers, and licensed nurses, including agency, have received re-training by the Regional Clinical Nurse, on process of full body skin assessments x three (3) days upon admission and then weekly skin audits by 11/06/2021, by the Regional Clinical | |

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| F 686 | Continued From page 22<br>skin tear and had length 2.5 cm, width 1.6 cm, and depth 0.1 cm. No tunneling was observed and had mild serous draining. The sacrum wound was stage 4 and had length 6.1 cm, width 3.4 cm, and depth 1.9 cm. There was undermining at 9 o ' clock at 1.1 cm. No tunnel observed and had yellow necrotic tissue. There was moderate serosanguinous drainage with moderate odor. The left ischium was a stage 4 pressure ulcer and had length 2.9 cm, width 2.0 cm, and depth 1.1 cm. No tunneling was observed. Yellow necrotic tissue was present. Status: sacral and ischial wounds were improving. Right toes all had black necrotic tissue and unstageable.<br><br>Resident #6 ' s treatment administration record (TAR) for October 2021 revealed several treatments were not signed as completed.<br><br>The right toes had an order dated 6/20/21 to paint with betadine each day scheduled at 2:30 pm: dates 10/1/21 - 10/4/21 and 10/6/21 - 10/10/21 had no initials documented for care completed.<br><br>The right ischium had an order dated 7/22/21 to cleanse and pack with wet Dakin ' s 0.5% solution (antiseptic medication) and cover with a DSD. There were no initials entered for care completed on the 2:30 pm block for 10/1/21 - 10/4/21 and 10/6/21 - 10/10/21.<br><br>The left ischium had an order dated 7/22/21 to cleanse and pack with wet Dakin ' s 0.5% solution and cover with a DSD. There were no initials entered for care completed on the 2:30 pm block for 10/1/21 - 10/4/21 and 10/6/21 - 10/10/21.<br><br>The sacrum had an order dated 7/12/21 to | F 686 | Nurse. Newly hired facility nursing staff, including agency will be provided this education by the facility Director of Nursing/designee during their orientation period. Any licensed nurse who have not received this education by 12/10/21, will not be allowed to work.<br><br>Director of Nursing/designee completed all current residents Braden assessment to identify any risk for wound development by 11/6/2021. Assessments will continue quarterly and with any change in condition. Verified completion was conducted by Regional Clinical Nurse on 11/06/2021. Effective 11/6/2021, facility nursing staff, including agency will not be allowed to work until education has been completed by Director of Nursing/designee.<br><br># 4 - Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed:<br>Effective 11/6/2021, the Nurse Management Team (to include Director of Nursing, Unit Managers), will review in clinical morning meeting new admissions, discharge summaries for any hospital identified wounds, weekly skin audits, wound MD progress notes and daily treatment administration records, to ensure residents are receiving treatments to promote healing of current wounds. The audits will be documented on the Clinical Rounds Checklist five (5) x's per week x twelve (12) weeks. The Director of | |

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| F 686 | Continued From page 23<br>cleanse with wound cleanser daily wet Dakin ' s 0.5% solution and cover with a DSD. There were no initials entered for care completed on the 2:30 pm block for 10/1/21 - 10/4/21 and 10/6/21 - 10/10/21.<br><br>On 10/28 at 5:25 pm an interview was conducted with Nurse #1. Nurse #1 stated the TAR was not initialed because the wound care was not done.<br><br>A nurses ' note dated 10/11/21 documented that the facility nurse practitioner observed Resident #6 ' s pressure ulcers and determined that the right toe declined and appeared infected. An order to send the resident to the hospital was provided.<br><br>Resident #6 was hospitalized from 10/11/21 until 10/18/21 for treatment of his infected right foot toe.<br><br>The hospital discharge summary dated 10/18/21 for Resident #6 documented that the resident ' s right toe was infected, and he had acquired an osteomyelitis (infection of the bone) to that toe. The resident remained admitted for intravenous antibiotics and was discharged back to the facility with continued antibiotics. The ischiums and sacral pressure ulcers were stage 4.<br><br>Resident #6 ' s TAR documentation after readmission to the facility was as follows.<br><br>The left elbow had an order to cleanse, apply calcium alginate, and cover with DSD. There were no initials entered for care completed on the 2:30 pm block for 10/20/21 - 10/25/21 and 10/29/21. | F 686 | Nursing and/or Unit Manager will complete a summary of audit results that will be reviewed at the monthly Quality Assurance Performance Improvement committee meetings. X 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continual compliance.<br><br>Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on 11/06/2021. An Ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting will be held on 11/6/2021. Director of Nursing will present plan of correction to QAPI committee for any approval and any further recommendations (if any).<br><br>#5 - Completion date: 12/10/2021 | |

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The right 5th toe had an order to paint with betadine daily. There were no initials entered for care completed on the 2:30 pm block for 10/20/21 - 10/25/21 and 10/29/21.

The right ischium had an order to cleanse and pack wet with Dakin ' s solution and cover with DSD daily. There were no initials entered for care completed on the 2:30 pm block for 10/20/21 - 10/25/21 and 10/29/21.

The left ischium had an order to cleanse and pack wet with Dakin ' s solution and cover with DSD daily. There were no initials entered for care completed on the 2:30 pm block for 10/20/21 - 10/25/21 and 10/29/21.

The sacrum had an order to cleanse with wound cleanser, pack wet with Dakin ' s solution and cover with DSD. There were no initials entered for care completed on the 2:30 pm block for 10/20/21 - 10/25/21 and 10/29/21.

On 10/28 at 5:25 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned two nursing units due to lack of staff on 10/10/21 and 10/24/21 for day shift 7 am to 3 pm. Nurse #1 was asked to stay for one nurse assignment for evening shift 3 pm to 11 pm due to a lack of staffing on the same days. Nurse #1 stated that her additional day shift assignment included Resident #6 ' s wound care. Nurse #1 stated that she was not able to provide wound care and supervision (to include checking Resident #6 ' s air mattress inflation device for appropriate pressure) to any of the residents on the additional assignment, which included Resident #6 ' s wound care. Total residents for both nursing assignments were more than 30

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residents. The treatment administration record (TAR) was not initialed because the care was not done. Nurse #1 stated that she informed the Director of Nursing (DON) on both occasions. Nurse #1 stated that a lack of staffing was an ongoing problem and management was aware that care was not being completed. Nurse #1 was aware that 10/10/21 and 10/24/21 were not the only days in October 2021 that had insufficient staff and care was not completed as reflected in the blank TAR documentation.

On 11/4/21 at 2:10 pm an interview was conducted with the DON and Corporate Nurse Consultant. Both staff stated after a review of Resident #6 ' s TAR documentation for October 2021, if the resident was out of the facility there would be a star in the initial box and if there were no nursing staff initials documented, the care was not completed due to insufficient staffing. The DON stated she was made aware that wound care was not completed as ordered, not always when it happened. The DON stated that for the first three weeks in October 2021 the wound care family nurse practitioner was not available, and the assigned residents ' wounds were not assessed and measured during this time. The DON stated that there was not a wound care nurse and assigned nursing staff had not measured the resident ' s wounds during October.

Resident #6 ' s quarterly Minimum Data Set dated 10/23/21 documented five stage IV pressure ulcers with four present on admission and 1 unstageable pressure ulcer. Resident #6 ' s weight was 168 pounds.

The care plan was not updated after

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hospitalization.

The wound care family nurse practitioner progress note dated 10/26/21 documented right elbow pressure ulcer (started as a skin tear) had length 2.6 cm, width 0.8 cm, and depth 0.1 cm. There was scant serous drainage, and the wound was declining. Sacral wound had length 7.3 cm, width 5.1, and depth 3.2. There was a tunnel of 6.4 cm (new). Around the wound was red. There was yellow necrotic tissue and moderate foul-smelling drainage. The wound was declining. The left ischium had length 4.5 cm, width 4.4 cm, and depth 3.4 cm. Around the wound was red. There was yellow necrotic tissue with minimal serosanguinous drainage. The wound was declining. The right ischium had length 4.1 cm, width 4.2 cm, and depth 3.1cm. Around the wound was red. There was yellow necrotic tissue with minimal serosanguinous draining. The wound was declining. Right foot toes: 2nd, 3rd, and 4th toes were now open and declining. There was 100% necrotic tissue with no drainage.

On 10/28/21 at 10:10 am an observation was done of Resident #6 in his pressure reduction air mattress bed. The resident was slightly off to his left leaning on his left elbow. Observation of the air flow pressure device for the mattress indicated a red light on "maintenance" and the light for pressure by weight had indicated less than 100 pounds (lbs). The resident had a wound dressing to his left elbow, bilateral shins, and right heel and foot. Both legs were edematous. The resident ' s heels were off the bed. The air mattress was soft to the touch, pressure was below 100lbs and then disappeared on the indicator.

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On 10/28/21 at 10:40 am an interview was conducted with Resident #6. The resident complained that his sacral pressure ulcer was hurting and thought the mattress was "soft and had been soft." The resident did not know why. He stated that he had several open areas in his skin. The resident stated that his dressings were not always changed. The resident stated that he had received his pain medication but was uncomfortable on the bed.

On 10/28/21 at 12:15 pm an observation was done of Resident #6 in his pressure reduction air mattress bed. The resident was slightly off to his left leaning on his left elbow. Observation of the air flow pressure device for the mattress indicated a red light for "maintenance" and the light for pressure by weight was indicating less than 100 lbs.

On 10/28/21 at 2:40 pm an observation was done of Resident #6 in his pressure reduction air mattress bed. The resident was slightly off to his left leaning on his left elbow. Observation of the air flow pressure device for the mattress indicated a red light for "maintenance" and the light for pressure by weight had indicated less than 100 lbs

On 10/28/21 at 4:10 pm an interview was conducted with Nurse #4 who was assigned to Resident #6. She stated she was in earlier to check Resident #6 ' s air mattress control box to see if it was lit. She was not aware that the device had a maintenance red light lit. She did not know who would trouble shoot/fix the mattress air pressure and would need to inform maintenance. She stated that the resident does not like to be turned because it caused him pain.

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On 10/28/21 at 5:10 pm an observation was done of Resident #6 on his pressure reduction air mattress bed. The resident was slightly off to his left leaning on his left elbow. Observation of the air flow pressure device for the mattress indicated a red light on "maintenance" and the light for pressure by weight was indicating less than 100 lbs.

On 10/29/21 at 6:45 am an observation was done of Resident #6 in his bed. The pressure reduction air mattress was inflated, and the pressure monitor red maintenance light was no longer lit. The pressure light indicated it was set at 1000 lbs.

On 10/29/21 at 7:00 am an interview was conducted with Nurse #6 night-shift nurse assigned to Resident #6. She stated she looked at the air mattress control device to make sure it was lit and observed the control device during interview. (Nurse #6 was not aware that it was set to 1000 lbs).

On 10/29/21 at 7:55 am an interview was conducted with the Activities Coordinator/Medication Aide (AC/MA). She was assigned to Resident #6 for day shift. She stated the resident was on a pressure reduction air mattress and looked at the pressure regulation device at the end of the bed, not just that it was lit but that it was providing proper pressure. The setting was set to 1000 lbs. She observed the pressure device during interview and had not commented if the pressure was set at the proper setting for the resident.

On 10/29/21 at 11:10 am an observation was

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done of Resident #6 ' s wound care. Care was provided by Nurse #7. She commented that the pressure ulcers to the sacrum and 2 ischiums were deep and without signs and symptoms of infection. Nurse #7 observed and unlocked the pressure reduction mattress because the setting was at 1000 lbs. Nurse #7 changed the setting to 200 lbs to match up closer to the resident ' s weight. The resident was noted to sink in the center almost to the frame of the bed. Nurse #7 stated that there was an air mattress beneath the resident ' s torso. The DON entered the room and took a picture of the air mattress pressure device and serial number. The DON commented that the air mattress device was broken and would need to be replaced. The DON commented that 1000 lbs was not the correct pressure for Resident #6.

On 10/29/21 at 12:10 pm an interview was conducted with the DON. The DON stated she did not know the air mattress device was not working until today and she did not know how long it had not been operating correctly. Staff had not reported that the mattress was in maintenance mode. The DON was aware that Resident #6 ' s pressure ulcer had declined and that the pressure reduction bed was part of the resident ' s plan to prevent further pressure ulcer. She said the bed would be replaced.

On 10/29/21 at 1:40 pm an interview was conducted with the wound family nurse practitioner for Resident #6. She stated that Resident #6 was assessed and measured on 10/26/21 and all pressure ulcers had declined. She stated that an inoperable pressure reduction bed that was too soft or too hard would not provide pressure reduction and would harm frail,

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pressure ulcerated tissue. She stated that Resident #6 was a high risk for infection and sepsis and daily wound care was important to prevent infection. She stated that without pressure reduction and wound care the wounds would be expected to decline. She stated she was aware that there were no assessments and measurements of the residents that were being followed for wound for the prior 3 weeks to the 10/26/21 visit, staff was unavailable.

On 11/1/21 at 10:32 am an interview was conducted by telephone with the facility physician. He stated that an air mattress pressure reduction bed was for pressure reduction. If the mattress was too soft or too hard (not operating), it would cause undue pressure and injury.

On 11/4/21 at 11:10 am an interview was conducted with the facility physician. He stated that if the wound care was not completed as ordered or missed, the wound could become infected or worsen (larger). He stated that he was not made aware that Resident #6 ' s wound care was not completed as ordered and was aware that the resident was hospitalized for his pressure ulcer infection in October 2021 (10/11/21 to 10/18/21) and was aware that all the pressure ulcers had declined (wound nurse practitioner visit of 10/26/21). He stated that residents informed him they waited for wound care and the assigned nurse informed the resident they would return but had not returned. He stated that the failure to provide wound care for Resident #6 contributed to his infection.

2. Resident #15 was admitted to the facility on 5/2/18 with the diagnoses of neurological disorder and muscle weakness.

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Resident #15 ' s quarterly Minimum Data Set dated 8/8/21 documented an intact cognition. His active diagnosis was muscle weakness. Pressure ulcer was not coded.

Resident #15 ' s admission Braden Scale documented he was a high risk for pressure ulcer.

Resident #15 ' s care plan documented a problem onset dated 5/9/19 at risk for pressure ulcers related to his diagnosis, immobility, and incontinence. Interventions included weight shift and daily observation of skin.

Resident #15 ' s nurses ' note written by Nurse #9 dated 9/22/21 documented right buttocks (ischium) open area noted that went from skin abrasion to stage 2 quickly, in a matter of days.

The wound had declined with necrotic tissue. Resident #15 was planned for surgical consult. A new order Physician order dated 9/22/21 was written for wound care to right buttock was cleanse with wound cleanser, pat dry, apply medi-honey, and cover with a dry sterile dressing (DSD) every day and as needed for soiling.

On 11/5/21 at 3:00 pm an interview was conducted with Nurse #9. She stated that she was assigned to Resident #15. She had identified the skin abrasion to the ischium which she covered with a DSD that was now a stage 2 and Medi-honey and dressing was ordered for each day. On 9/22/21 Nurse #9 stated she observed Resident #15 ' s ischium wound which had declined to a black necrotic unstageable pressure ulcer the size of her fist. The facility nurse

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practitioner was informed of the wound decline and assessed the resident by video. The facility nurse practitioner gave orders for a surgical consult: concern for infection and needed debridement of eschar tissue. Nurse #9 informed the nurse practitioner that Resident #15 had not received wound care on several occasions in September 2021. Nurse #9 stated that she was aware that wound care was not being completed due to insufficient staffing and observed on the North Unit that staffing had not completed wound care even when staffed. Nurse #9 would round with the wound care nurse practitioner each week and reviewed the TAR. Nurse #9 stated that the wound care was not initialed as being completed for several residents. After Nurse #9 stated she inquired why there were no initials, she was informed by nursing that the care was not completed. Nurse #9 stated she informed the Director of Nursing (DON) of the failure to provide wound care to multiple residents on multiple dates during the month of September 2021. Nurse #9 stated that the failure to provide wound care was discussed in the morning stand up meeting (daily clinical meeting where management was present). Nurse #9 stated that the facility was aware that wound care was not being completed. Nurse #9 had changed her employment status to as needed and had not been back in the facility since 10/1/21.

Resident #15 ' s Treatment Administration Record (TAR) for September 2021 documented care for right buttock as ordered starting on 9/23/21 at 2:30 pm. There were no initials on the TAR to indicate care was provided for the dates of 9/23/21 - 9/26/21.

Resident #15 ' s TAR for October 2021

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documented care for right buttock as ordered at 2:30 pm. There were no initials for care provided dated 10/1/21 - 10/6/21 (star in signature/initial block for remainder of the month for 10/7/21 hospitalization).

Resident #15 ' s nurses ' note dated 10/6/21 documented he was sent out for surgical consult of the pressure ulcer stage "5" ischium wound per the wound nurse practitioner.

Resident #15 ' s discharge MDS dated 10/6/21 documented an intact cognition and stage 4 (ischium) pressure ulcers.

Resident #15 ' s hospital history and physical dated 10/7/21 documented inpatient admission for a worsening pressure ulcer now a stage 4 with deep wound infection. Plan for operative debridement.

Resident #15 ' s facility nurse practitioner ' s progress note dated 10/11/21 for follow-up on sacral wound after debridement documented there was skin breakdown to sacrum and right buttocks. The resident ' s wound was examined last week (before debridement), and it had black eschar circular of right buttock and there was evidence of purulent drainage on his dressing. Resident was sent to the hospital for debridement for the black eschar and purulent drainage (10/7/21). The wound tissue was now pink with serous drainage and was packed with gauze and no current signs of infection. The resident had an elevated which cell count while in the hospital.

Resident #15 ' s physician order dated 10/11/21 indicated to clean the ischium with Dakin ' s, pack with soaked Dakin ' s, and DSD twice a day.

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Resident #15 ' s October TAR for wound care order beginning 10/11/21 documented no initials for care provided 10/11/21 pm - 10/15/21 for twice a day dressing, no initials for 10/17/21 - 10/18/21 twice a day dressing, no initials for 10/20/21 - 10/22/21 for twice a day dressing, and no initials for 10/23/21 in the pm.

Resident #15 ' s facility nurse practitioner progress note dated 10/18/21 documented follow up for decubitus ulcer. Approximately 2 weeks ago the resident had surgical debridement. She ordered wound care nurse practitioner to follow closely. Order for Dakin ' s solution cleanse and pack with Dakin ' s wet-to-dry dressing twice a day.

A review of Resident #15 ' s medical record had no documentation of care by the wound care nurse practitioner.

Resident #15 ' s physician progress note date 10/25/21 documented the resident had an altered mental status, low oxygen saturation of 82%, pulse of 102 and blood pressure of 80/69. The resident was sent to the hospital.

Resident #15 ' s discharge summary dated 10/28/21 documented the resident ' s diagnoses as sepsis, acute encephalopathy, elevated heart enzymes (shows injury), and fast ventricular heart rate. Antibiotic coverage was provided. Suspected sacral ulcer infection. Hospital physical therapy recommended a motorized wheelchair to get the resident up off his sacral ulcer.

Resident #15 ' s physician order dated 10/28/21

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was right ischial wound stage 4 pressure ulcer clean with Dakin ' s and pack with Dakin ' s-soaked gauze and cover with a DSD twice a day.

Resident #15 ' s TAR for October of 2021 order began 10/28/21 had initials for care provided except for 10/28/21 10:30 pm and 10/30/21 2:30 pm.

On 11/3/21 at 2:02 pm an interview was conducted with the Guardian/RP (responsible party) for Resident #15. The RP stated that the resident acquired a pressure ulcer in September that quickly worsened. The resident had informed her his wound care was not being completed regularly and he was not getting out of bed. The resident has had to have two debridements to his ischium/sacral pressure ulcer due to infection and necrotic tissue which was a change. The resident had advancing disease and was at risk for sepsis.

On 11/4/21 at 11:10 am an interview was conducted with the facility physician. He stated that if the wound care was not completed as ordered or missed, the wound could become infected or worsen. He stated that he was not made aware by the facility that Resident #15 ' s wound care was not completed as ordered and was aware that the resident required debridement. He stated that residents informed him they waited for wound care. The assigned nurse stated to residents they would return and had not returned when I saw the resident later in the day. The physician did not indicate which residents informed him. He stated that a failure to provide wound care would be a contributor to infection. The physician was informed that an

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interview with the facility nurse practitioner that he supervised would need to be interviewed.

An interview was attempted with the facility nurse practitioner on 11/4/21 and 11/5/21. Message was not able to be left, the mailbox was full. The supervising facility physician was informed on 11/4/21 by telephone message and no return call was provided from the facility nurse practitioner or physician.

On 11/4/21 at 2:10 pm an interview was conducted with the DON and corporate nurse consultant. Both staff stated TAR documented if the resident was out of the facility there would be a star in the initial box and if there were no nursing staff initials documented, the care was not completed due to insufficient staffing. The DON stated she was made aware that wound care was not completed as ordered, but not always when it happened. The DON stated that for the first three weeks in October 2021 the wound care family nurse practitioner was not available, and the residents ' wounds were not assessed and measured during this time. Resident #15 was not seen by the wound care nurse practitioner. The DON stated that there was not a wound care nurse and assigned nursing staff had not measured the resident ' s wounds during the first three weeks in October. Assigned nursing staff were responsible to provide wound care as ordered and there was no replacement for the wound care practitioner ' s assessment and measurement.

On 11/4/21 at 2:05 pm an interview was conducted with Resident #15. He stated that he had a wound to his backside that had recent surgery. He stated that the staff does not always

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change his dressing, "they missed some." He stated that he had not gotten up because his wheelchair was too small, and he needed to lean back which caused him to be stuck in bed. The resident stated the surgeon informed him he should be getting up to relieve pressure on his backside.
On 11/4/21 at 2:05 pm an observation was done of Resident #15. He was in his bed with an egg-crate mattress (foam mattress). The resident was large and filled the bed. There was a pressure reduction cushion on the wheelchair. The wheelchair appeared to be too narrow for the resident ' s width and had no option to lean back.

The Administrator was notified of the immediate jeopardy on 11/5/2021 at 7:12 pm.

On 11/6/2021 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following:

Allegation of Compliance F 686 Pressure Ulcers

The facility failed to provide sufficient nursing staff to ensure residents received consistent pressure ulcer wound care as ordered which resulted in wound decline, infection, needed surgery, and antibiotic administration. (Residents #6 and #15).
Resident #6 was readmitted with diagnosis: chronic osteomyelitis, epilepsy, urinary retention and pressure ulcer. TARS reveal scattered missing wound treatments during the last month. He was discharged to the hospital on 10/11/21 for treatment of a declining wound and readmitted on 10/18/2021. On 10/29/2021, it was noted that his air mattress had malfunctioned, and it was replaced. Resident # 6 was assessed for current wounds and treatments on 11/5/2021 by wound

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nurse practitioner, treatment nurse and nurse consultant. Treatment orders are to continue at this time, after reevaluation. Air mattress is functioning properly and checked every shift for continued function and resident is noted to be comfortable during wound evaluation.
Resident #15 was originally admitted on 05/02/2018 with diagnosis: multiple sclerosis, failure to thrive, and pressure ulcer. Wound was noted on 9/22/2021 to extend to the right ischial area with identification of the right buttock which is noted in the residents ' wound records as a Stage 4. Resident was transferred to the hospital for left sided facial drooping and increased aphasia while participating in therapy. During hospitalization it was noted that resident ' s wound had necrotic eschar and wound was debrided during this hospitalization. Resident was readmitted on 10/28/2021 with new orders for wound which were initiated. Resident was seen by in-house treatment nurse and wound nurse practitioner on 11/05/2021. Resident was comfortable and had no pain with treatment provided. Air mattress initiated and functioning properly on 11/06/2021.
The Facility currently has a total of ten (10) residents with wounds, as of 11/05/2021. The Facility has employed a Full-Time wound Nurse for the facility 11/5/2021. The Corporate Clinical Nurse completed a Competency with the facility wound nurse and Director of Nursing to ensure they were competent in wound identification, measuring, treatments and healing.
The Director of Nursing and Administrative Nurses completed a Head- to- toe assessment of current residents on 11/04/2021, to evaluate current skin condition and identify any new skin deficiencies. Any areas identified were cross referenced with resident ' s Treatment

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Administration Record to ensure treatments were in place and being implemented timely. Any new areas that would have been identified the resident ' s attending physician would have been notified and treatment order obtained. There were no new areas noted.
11/4/2021, Regional Clinical Nurse completed a review of nurse ' s notes, for the last 30 days. No new concerns were noted. This included, an audit of the previous weeks ' wound progress notes, reviewed for current wound orders and were updated as applicable. This also included updating resident care plans and care guides to ensure interventions for each resident to prevent and treat pressure ulcers.

Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete:

On 11/4/2021, all residents with air mattresses were observed for functioning equipment by the director of nursing and administrative nurses. Orders were added to check function every shift by clinical nurses. There is currently eight (8) air mattress ' , on residents ' , in the facility.

Director of Nursing/designee has re-educated, licensed nursing staff, to include agency on process of full body skin assessments x three (3) days upon admission and then weekly skin audits by 11/06/2021.

Director of Nursing/designee completed all current residents Braden assessment to identify any risk for wound development by 11/6/2021. Assessments will continue quarterly and with any

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change in condition. Verified completion was conducted by Regional Clinical Nurse on 11/06/2021.

Director of Nursing/designee re-educated certified nursing assistants, to include agency certified nursing assistance, on completing shower assessments, turning and repositioning and alleviating pressure by 11/06/2021.

Effective 11/6/2021, facility nursing staff, including agency will not be allowed to work until education has been completed by Director of Nursing/designee.

Newly hired facility nursing staff, including agency will be provided this education by the facility Director of Nursing/designee during their orientation period. The Director of Nursing and/or designee will review all new hires to include agency education prior to working shift.

Root cause Analysis: due to multiple facility leadership changes over the past several months, it was identified that the staff was lacking communication in expectations for wound management for prevention and treatment of pressure ulcer program. Current Director of Nursing will be provided support and redirection to assure vigilance in monitoring the Wound Management Program. Current clinical leadership in facility will be provided support and expectations by the Regional Clinical Nurse.

An Ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting will be held on 11/6/2021. Director of Nursing will present plan of correction to QAPI committee for any approval and any further recommendations (if any).

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Effective 11/6/2021, the Nurse Management Team (to include Director of Nursing, Unit Managers), will review in clinical morning meeting new admissions, discharge summaries for any hospital identified wounds, weekly skin audits, wound MD progress notes and daily treatment administration records. The audits will be documented on the Clinical Rounds Checklist five (5) x ' s per week x twelve (12) weeks.

Effective 11/6/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.

The immediate jeopardy removal date is 11/7/21.

The credible allegation was validated on 11/10/21.

An Ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on 11/6/2021.

Inservice education was provided on 11/6/2021, 11/7/2021 and 11/8/2021. No new hires out of orientation.

On 11/4/2021 the Regional Clinical Nurse completed a review of nurse ' s notes for the last 30 days.

The Director of Nursing provided education re: completing shower assessments, turning, and repositioning and alleviating pressure by

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| F 686 | Continued From page 42<br>11/06/2021.<br><br>The DON had completed re-education with current licensed nurses, including agency staff. If the wound nurse was not available, it would be communicated to the licensed nurses by the DON to provide treatments as ordered by the physician.<br><br>Effective 11/6/2021, the Nurse Management Team, to include Director of Nursing and Unit Managers, will review in clinical morning meeting new admissions, discharge summaries for any hospital identified wounds, weekly skin audits, wound physician progress notes, and daily treatment administration records.<br><br>The Director of Nursing and Administrative Nurses completed a head- to- toe assessment of current residents on 11/04/2021.<br><br>Most recent wound care note from physician services were as follows:<br><br>· All residents with air mattresses were observed for functioning equipment.<br><br>· Director of Nursing/designee completed all current residents ' Braden assessment to identify any risk for wound development. Assessments will continue quarterly and with any change in condition. Verified completion was on 11/06/2021.<br><br>Staffing interviews were conducted on 11/10/21 which included 12 agency and employee nursing staff. All staff verbalized in-service for pressure ulcer care and operation of equipment and what to do when there was inadequate staffing. | F 686 | | |

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| F 686 | Continued From page 43<br><br>Immediate jeopardy was removed on 11/7/21. | F 686 | | |
| F 725 SS=K | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews of the residents, staff, guardian, and medical staff, the facility failed to provide sufficient nursing staff to 1.) ensure residents | F 725 | F 725 Sufficient Nursing Staff:<br><br># 1 - Address how corrective action will be accomplished for those residents found to | 12/10/21 |

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| F 725 | Continued From page 44<br>received consistent pressure ulcer wound care as ordered and pressure ulcer prevention. for 2 of 3 sampled residents (#6 and #15). 2.) Avoid significant medication errors for 3 of 3 sampled residents reviewed for medication administration (#12, #13 and #14); and 3.) Provide activities of daily living to a resident dependent on staff for nail care and hair washing for 1 of 3 sampled residents (#6).<br><br>Immediate Jeopardy began on 9/22/21 when there was insufficient staff to carry out wound treatments.for Residents #6 and 15 who both had significant decline to their wounds. The facility did not address insufficient staffing to complete resident ordered wound care and pressure reduction for pressure ulcer prevention. Immediate Jeopardy was removed on 11/7/2021 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to correct findings 2. and 3. and to ensure monitoring of systems are put in place and to complete employee in-service.<br><br>Findings included:<br>1. Cross refer to F686.<br><br>Based on record review, observation and interviews with resident, staff, guardian, Wound Family Nurse Practitioner and physician, the facility failed to: assess and document wounds consistently; provide wound treatments as ordered; and provide pressure relief from equipment that operated in accordance with manufacturer ' s instructions. These failures led to the development of new wounds, wounds that | F 725 | have been affected by the deficient practice:<br><br>Director of Nursing and Corporate Nurse Consultant completed a review of the medical record for Resident #12, #13, #14, #6, and #15, to ensure no negative outcomes due to missed medication and/or treatments. The attending physician for these residents were notified by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continued current medication and/or treatments as ordered, and no new orders were obtained Residents #12, #13, #14, #6 and #15 have been receiving their medications and/or treatments as ordered by their attending physician as of 12/10/21. The director of nursing, schedule, and Corporate Nurse Consultant reviewed current staffing schedule to ensure staffing was adequate for resident census. This was completed 11/6/21<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>Any Residents had the potential to be affected by the alleged deficient practice.<br><br>The Corporate Clinical Nurse along with the Director of Nursing, and Scheduler, completed a master schedule, as of 11/6/21, that will ensure proper staffing levels, including RN coverage 8 hours/day for 7 days/week, based on current | |

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| F 725 | Continued From page 45<br>worsened in size and became infected (#6 and #15), and wounds that resulted in hospital interventions. These problems affected 2 of 3 sampled residents with pressure ulcers.<br>Resident #6 developed a new pressure ulcer on the elbow, developed larger wounds on the hips and sacrum that became infected, acquired osteomyelitis of the toe and expressed pain from inadequate pressure relief while in bed.<br>Resident #6 required hospitalization for treatment of the osteomyelitis with intravenous antibiotics.<br>Resident #15 developed a new wound that advanced to the highest stage with infection. This resulted in surgical debridement and hospital treatment.<br><br>On 10/28/21 at 1:05 pm an interview was conducted with the Staffing Coordinator/Medication Aide. She stated when staff call out, they were informed to call the Director of Nursing. She stated scheduling nursing staff had been rough over the past couple months and the facility only has approximately 10 employee nursing assistants (NA). The facility has had to use agency staff from 4 different staffing agencies to fill shifts for (licensed nurses and nursing assistants). Currently, the facility is short NA staff, and have approximately 4-5 shifts open on first shift, 2-3 shifts open on second shift, and 3 shifts open on night shift. She stated she would contact the staffing agency 1 to 2 weeks in advance to schedule. Some agency staff cancel. When there were no staff available, the nursing staff would have to take on more residents in their assignment. She stated she worked 16-20 hours a day to help fill in as a medication aide. She stated that she had not been able to schedule a registered nurse for 8 hours each day. When there was not enough staff, she would have to | F 725 | resident census to ensure that resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely.<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>The Director of Nursing, Staffing Coordinator, and Executive Director were re-educated by the Clinical Nurse Consultant on ensuring proper staff coverage, including Registered Nurse coverage 8 hours/day, 7 days/week, based on current facility census, to ensure resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely. This re-training was completed on 12/10/21.<br>Director of Nursing, unit managers and regional nurse consultant are providing re-training with licensed nurses, medication aides, certified nursing assistants on the need to ensure all residents receive grooming, nail care, bathing, assistance with meals, treatments, and medications timely. This training will be completed by 12/10/21.<br>Any nursing employee, including agency who does not receive this training by 12/10/21, will not be able to work until training is completed.<br>Director of Nursing has completed re-education with current Licensed Nurses, including Agency staff, If the wound nurse is not available, it will be communicated to the licensed nurses by | |

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| F 725 | Continued From page 46<br>assign licensed nurses about 30 residents and NAs about 20 resident each for their shift. This type of assignment applied to all shifts.<br><br>On 11/4/21 an interview was conducted with the Administrator. She stated that she was working on contracting with additional staffing agencies to address the facility ' s insufficient staffing problem. There was a job fair planned for 11/5/21. The current contracted agency staff were unreliable and frequently did not show up for their assignment. Part of the new contract plan was for the agency to hold staff accountable when they do not show and to give adequate notice when staff cannot work.<br><br>The Administrator was notified of the immediate jeopardy on 11/5/2021 at 7:12 pm.<br><br>On 11/6/2021 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following.<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance:<br><br>The facility failed to provide sufficient nursing staff to ensure resident received consistent pressure ulcer would care as ordered which resulted in wound decline, infection, needed surgery, and antibiotic administration. (Residents #6 and #15).<br><br>All Residents had the potential to be affected by the alleged deficient practice.<br><br>The Facility currently has a total of ten (10) residents with wounds, as of 11/5/21. The | F 725 | the Director of Nursing to provide treatments as ordered by the physician. If the licensed nurse cannot complete the treatments within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing and/or facility Executive Director. The Director of Nursing and/or Unit Manager will complete the assessment and measurements. This training will be completed as of 11/6/21, any current nurse, including agency, who is unable to receive this training will not be allowed to work until training is completed by the Director of Nursing and/or designee. New Licensed Nursing staff, including agency, will receive this training at time of their orientation. Anyone who has not been educated by 12/10/2021 will no be allowed to work until training has been completed.<br><br># 4 - Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;<br><br>The facility Director of Nursing and Human Resources has re-implemented a recruiting initiative program beginning 10/30/21 & 11/1/21, for licensed nurses, Certified Medication Aides (CMAs), Certified Nursing Assistants (CNA), this includes utilizing Agency Supplemental Staffing to maintain appropriate staffing numbers, implementing a bonus program for full-time and referral bonus' for their current licensed nurses, as well as sign-on bonus for new employees. Executive Director will implement a daily labor meeting that will include, Director of | |

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| F 725 | Continued From page 47<br>Facility has employed a Full-Time wound Nurse for the facility 11/5/21. The Corporate Clinical Nurse completed a Competency with the facility wound nurse & Director of Nursing to ensure they were competent in wound identification, measuring, treatments and healing.<br><br>The Director of Nursing and/or Administrative Nurses completed a Head-to-Toe assessment of current residents on 11/4/2021, to evaluate current skin condition and identify any new skin deficiencies. Any areas identified were cross referenced with resident ' s Treatment Administration Record to ensure treatments were in place and being implemented timely. Any new areas that would have been identified the resident ' s attending physician would have been notified and a treatment order obtained. There were no new areas noted.<br><br>The facility Director of Nursing and Human Resources has re-implemented a recruiting initiative program beginning 10/30/21 & 11/1/21, for licensed nurses, Certified Medication Aides (CMAs), Certified Nursing Assistants (CNA), this includes utilizing Agency Supplemental Staffing to maintain appropriate staffing numbers, implementing a bonus program for full-time and referral bonus ' for their current licensed nurses, as well as sign-on bonus for new employees. The facility governing body along with Regional Director made the decision, 9/27/21, to stop new admissions to ensure facility stability of current staffing and regulatory concerns.<br><br>10/30/21, The facility Director of Nursing and Human Resources is utilizing Certified Medication Aides to assist with Medication Administration with the oversight of a Licensed Nurse, to allow | F 725 | Nursing (DON), Staffing Coordinator, Human Resources, and other members of the Leadership Team, to review current daily staffing needs and forecast the remaining week, including weekends to ensure sufficient staff is available for the resident needs, to include medication administration and wound care, in the facility. This meeting began 11/5/21. Any identified need for staff, the executive director will authorize, overtime/bonus pay for current staff to fill open positions and/or authorize agency usage from the facility contracted staffing to ensure the facility has staffing to provide current resident care, including resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely.<br>The Director of Nursing and/or Executive Director will monitor staffing five times a week during the daily Stand-up/clinical meeting. The Director of Nursing and/or designee will monitor the staffing daily 7 days per week to ensure that all callouts are reported timely, and coverage is available to include a Registered Nurse for 8 hours 7 days per week.<br>The Executive Director will complete a summary of monitoring efforts and present at the monthly Quality Assurance and performance Improvement meeting, to ensure continued compliance<br><br># 5 - Completion date: 12/10/2021 | |

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| F 725 | Continued From page 48 | F 725 | | |

Licensed Nursing staff more time to perform assessments and treatments. Director of Nursing has been having conversations with the licensed nurses about the expectations of the program to be completed by 11/6/21.

Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete:

Executive Director will implement a daily labor meeting that will include, Director of Nursing (DON), Staffing Coordinator, Human Resources, and other members of the Leadership Team, to review current daily staffing needs and forecast the remaining week, including weekends to ensure sufficient staff is available for the resident needs, to include wound care, in the facility. This meeting began 11/5/21.
The Corporate Clinical Nurse along with the Director of Nursing, and Scheduler, has completed a master schedule, as of 11/6/21, that will ensure proper staffing levels based on current resident census to ensure that resident wound treatments are completed timely.

Director of Nursing has completed re-education with current Licensed Nurses, including Agency staff, If the wound nurse is not available, it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. If the licensed nurse cannot complete the treatments within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing and/or facility Executive Director. The Director of Nursing and/or Unit Manager will complete the assessment and measurements.

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| F 725 | Continued From page 49 | F 725 | | |

This training will be completed as of 11/6/21, any current nurse, including agency, who is unable to receive this training will not be allowed to work until training is completed by the Director of Nursing and/or designee. New Licensed Nursing staff, including agency, will receive this training at time of their orientation.

Resident wound treatments will be validated by weekly observation rounds, 3 times a week, by the Director of Nursing and/or Unit Managers, to ensure treatments are timely and documentation is complete. The Corporate Clinical Nurse will be completing observation rounds, weekly x 4 weeks with the facility clinical staff to provide additional training regarding wound care prevention and treatments.
The Director of Nursing and/or Facility Administrator will monitor staffing 5 times a week during the daily Stand-up meeting. The director of nursing and/or designee will monitor the staffing daily 7 days per week to ensure that all call-outs are reported timely and coverage is available.

The Facility Administrator will complete a summary of monitoring efforts and present at the monthly Quality Assurance and Performance Improvement meeting, to ensure continued compliance

The facility alleges the removal of the Immediate Jeopardy on Nov 7, 2021,

The Administrator and/or Director of Nursing is responsible for assuring corrective actions to ensure continued compliance.

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| F 725 | Continued From page 50<br>The credible allegation was validated on 11/10/21.<br><br>On 11/5/21 the Corporate Recruiter and facility Human Relations Department completed a job fair at the facility which resulted in 2 new hires, a medication aide and a nurse.<br><br>An Ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on 11/6/2021.<br><br>The Executive Director implemented a daily labor meeting. The first meeting was on 11/5/21 and it addressed staffing needs for Friday through Sunday. An 11/8/21 meeting discussed the week ahead and open nursing spots and the 11/9/21 noted 2 new staff members in orientation, 1 medication aide and 1 nurse for night shift.<br><br>The Corporate Clinical Nurse along with the DON and scheduler had completed a master schedule as of 11/6/21 that would ensure proper staffing levels based on current resident census to ensure that resident wound treatments would be completed as ordered.<br>The Director of Nursing had completed re-education with current licensed nurses, including agency staff was documented.<br>Resident wound treatments had been validated by weekly observation rounds, 3 times a week.<br><br>The Director of Nursing and/or Facility Administrator had monitored staffing 5 times a week during the daily stand-up meeting.<br>The immediate jeopardy was removed on 11/7/21.<br><br>2. Cross refer to F 760. | F 725 | | |

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| F 725 | Continued From page 51<br>Based on record review and interviews with the staff and Medical Doctor the facility failed to prevent significant medication errors by omitting scheduled doses of a medication used to treat atrial fibrillation (Resident #14) and failed to check blood glucose levels to determine if sliding scale aspart insulin (a fast-acting antidiabetic medication) was needed and omitted scheduled doses of detemir (a long-acting antidiabetic medication) (Resident #12) and failed to check blood glucose levels and omitted scheduled doses of aspart before meals and scheduled doses of detemir (Resident #13) for 3 of 3 residents reviewed for medication errors.<br><br>3. Cross refer to F 677.<br>Based on record review, observation, and interview of resident and staff, the facility failed to provide hair wash and nail care to a dependent resident (Resident #6) for 1 of 3 residents sampled. | F 725 | | |
| F 727 SS=E | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. | F 727 | | 12/10/21 |

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| F 727 | Continued From page 52<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with staff, the facility failed to have a Registered Nurse (RN) 8 hours a day for 7 days a week for 3 of 6 days reviewed for staffing (10/25/21, 10/26/21, and 10/28/21).<br><br>The findings included:<br><br>Review of the daily staffing hours revealed on 10/25/21 and 10/26/21 the census was 92 with no RN for 24 hours. On 10/28/21 the census was 91 with no RN for 24 hours.<br><br>An interview was conducted on 10/28/21 at 1:05 PM with the Staffing Coordinator (SC). The SC confirmed she had not been able to schedule an RN each day for 8 hours 7 days a week. The SC revealed she currently worked with 4 staffing agencies in an attempt to meet the needs of nursing schedule.<br><br>During an interview on 10/29/21 at 4:38 PM the Director of Nursing revealed there had been times no RN was scheduled for 8 hours a day and stated it had been difficult to find RNs available to work. The DON revealed she was not counted on the RN hours but had worked 12 hours shifts. | F 727 | F 727 – RN 8 Hrs/7 days/Wk, Full Time DON:<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Director of Nursing and Corporate Nurse Consultant completed a review of the medical record for Resident #12, #13, #14, #6, and #15, to ensure no negative outcomes due to missed medication and/or treatments. The attending physician for these residents were notified by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continued current medication and/or treatments as ordered, and no new orders were obtained Residents #12, #13, #14, #6 and #15 have been receiving their medications and/or treatments as ordered by their attending physician as of 12/10/21.<br><br>The director of nursing, schedule, and Corporate Nurse Consultant reviewed current staffing schedule was adjusted on 11/6/21, to ensure Registered Nurse (RN) coverage, 8 hours/day; 7 days/week, was in place, to provide supervision.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the deficient practice:<br>Any Residents had the potential to be | |

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| F 727 | Continued From page 53 | F 727 | affected by the alleged deficient practice.<br><br>The Corporate Clinical Nurse along with the Director of Nursing, and Scheduler, completed a master schedule, as of 11/6/21, that will ensure proper staffing levels, including RN coverage 8 hours/day for 7 days/week, based on current resident census to ensure that resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely.<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>The Director of Nursing, Staffing Coordinator, and Executive Director were re-educated by the Clinical Nurse Consultant on ensuring proper staff coverage, including Registered Nurse coverage 8 hours/day, 7 days/week, based on current facility census, to ensure resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely. This re-training was completed on 12/10/21.<br>Director of Nursing, unit managers and regional nurse consultant are providing re-training with licensed nurses, medication aides, certified nursing assistants on the need to ensure all residents receive grooming, nail care, bathing, assistance with meals, treatments, and medications timely. This training will be completed by 12/10/21.<br>Any nursing employee, including agency | |

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who does not receive this training by 12/10/21, will not be able to work until training is completed.
Director of Nursing has completed re-education with current Licensed Nurses, including Agency staff, If the wound nurse is not available, it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. If the licensed nurse cannot complete the treatments within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing and/or facility Executive Director. The Director of Nursing and/or Unit Manager will complete the assessment and measurements. This training will be completed as of 11/6/21, any current nurse, including agency, who is unable to receive this training will not be allowed to work until training is completed by the Director of Nursing and/or designee. New Licensed Nursing staff, including agency, will receive this training at time of their orientation. Anyone who has not been educated by 12/10/2021 will not be allowed to work until training has been completed.

# - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed:

The facility Director of Nursing and Human Resources has re-implemented a recruiting initiative program beginning 10/30/21 & 11/1/21, for licensed nurses,

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| F 727 | Continued From page 55 | F 727 | Certified Medication Aides (CMAs), Certified Nursing Assistants (CNA), this includes utilizing Agency Supplemental Staffing to maintain appropriate staffing numbers, implementing a bonus program for full-time and referral bonus' for their current licensed nurses, as well as sign-on bonus for new employees.<br>Executive Director will implement a daily labor meeting that will include, Director of Nursing (DON), Staffing Coordinator, Human Resources, and other members of the Leadership Team, to review current daily staffing needs and forecast the remaining week, including weekends to ensure sufficient staff is available for the resident needs, to include medication administration and wound care, in the facility. This meeting began 11/5/21. Any identified need for staff, the executive director will authorize, overtime/bonus pay for current staff to fill open positions and/or authorize agency usage from the facility contracted staffing to ensure the facility has staffing to provide current resident care, including resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely.<br>The Director of Nursing and/or Executive Director will monitor staffing five times a week during the daily Stand-up/clinical meeting. The Director of Nursing and/or designee will monitor the staffing daily 7 days per week to ensure that all callouts are reported timely, and coverage is available to include a Registered Nurse for 8 hours 7 days per week.<br>The Executive Director will complete a | |

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| F 727 | Continued From page 56 | F 727 | summary of monitoring efforts and present at the monthly Quality Assurance and performance Improvement meeting, to ensure continued compliance.<br><br># 5 - Completion date: 12/10/2021 | |
| F 760 SS=E | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with the staff and Medical Doctor the facility failed to prevent significant medication errors by omitting scheduled doses of a medication used to treat atrial fibrillation (Resident #14) and failed to check blood glucose levels to determine if sliding scale aspart insulin (a fast-acting antidiabetic medication) was needed and omitted scheduled doses of detemir (a long-acting antidiabetic medication) (Resident #12) and failed to check blood glucose levels and omitted scheduled doses of aspart before meals and scheduled doses of detemir (Resident #13) for 3 of 3 residents reviewed for medication errors.<br><br>The findings included:<br><br>1.Resident #14 was admitted to the facility on 2/10/21 with diagnoses of hypertension and chronic diastolic heart failure. Resident #14 was discharged to the hospital on 9/26/21 and readmitted on 10/6/21. | F 760 | F760 – Resident are Free of Significant Med Errors:<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #14- no longer is at the facility. Director of Nursing and Corporate Nurse Consultant completed a review of the medical record for Resident #12, #13, #14, #6, and #15, to ensure no negative outcomes due to missed medication and/or treatments. The attending physician for these residents were notified by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continued current medication and/or treatments as ordered, and no new orders were obtained Residents #12, #13, #14, #6 and #15 have been receiving their medications and/or treatments as ordered by their attending physician as of | 12/10/21 |

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| F 760 | Continued From page 57<br><br>A review of the hospital discharge summary revealed Resident #14 was admitted on 9/26/21 for acute respiratory distress and diagnosed with a new onset of atrial fibrillation (an irregular heartbeat) but was not a candidate for anticoagulation (medications used to thin the blood) therapy. The discharge summary revealed the plan was to continue diltiazem (an antiarrhythmic medication) 120 milligrams (mg) give 1 tablet daily.<br><br>Review of a significant change Minimum Data Set (MDS) dated 10/10/21 assessed Resident #14's cognition as moderately impaired.<br><br>The care plan last revised on 10/12/21 identified cardiovascular disease diagnoses as being atrial fibrillation, congestive heart failure, and hypertension with the goal Resident #14 would not experience complications of cardiovascular disease through the next review. Interventions included administer cardiac medications as ordered.<br><br>A review of Resident #14's Medication Administration Record (MAR) for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented under the administration of diltiazem 120 milligrams scheduled at 8:00 AM.<br><br>A second review of the MAR revealed on 10/25/21 Resident #14 received the scheduled | F 760 | 12/10/21.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Complete Audit for all current resident's Medication/treatment administration records was completed by Director of Nursing and Regional Clinical Nurse to ensure and to identify any other residents' medications/treatments that were missed on 10/10/2021 and 10/24/2021. If there were any other omissions identified the resident's attending physician was notified on 10/28/21.<br>Facility Social Worker and Administrative Leadership completed interviews with current interviewable residents to ensure they have no identified concerns with receiving their medication timely. These interviews will be completed by 12/10/21. Any identified concerns will be taken through the facility Grievance process by the Social Worker and Executive Director.<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>The director of nursing and/or unit managers will be reviewing current resident medication/treatment records, for previous 24 hours, at the Clinical AM meeting, to ensure to ensure that residents are receiving their medication/treatments as ordered by their attending physician. If there are any noted omissions, the licensed nurse will be contacted for re-education, verification | |

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| F 760 | Continued From page 58<br>dose of diltiazem at 8:00 AM with a blood pressure reading of 145/79.<br><br>An interview was conducted on 10/28/21 at 5:25 PM with Nurse #1. Nurse #1 revealed on 10/10/21 and 10/24/21 she worked by herself on a unit with a 2-nurse assignment and was the only nurse till after 3 PM on both days. Nurse #1 revealed she was unable to administer all medication to residents on the second nurse assignment. Nurse #1 revealed she notified the Director of Nursing (DON) there was no nurse assigned to complete medication administration for the second nurse assignment on 10/10/21 and 10/24/21 and it was after 3:00 PM before a second nurse arrived to help.<br><br>An interview was conducted with the Medical Doctor (MD) on 11/4/21 at 9:43 AM. The MD revealed he considered diltiazem a significant medication and was aware Resident #14 was newly diagnosed with atrial fibrillation and not a candidate for anticoagulant medications. The MD stated staff on the later shift could see daily the medication was not administered and could have given the diltiazem.<br><br>2. Resident #12 was admitted to the facility on 3/13/21 with a diagnoses of type 2 diabetes mellitus and dementia.<br><br>Review of the quarterly MDS dated 8/20/21 assessed Resident #12's cognition as being severely impaired. The MDS medication review revealed insulin injections were given 7 days | F 760 | that medication/treatment was administered, and completion of documentation.<br>On 11/04/2021, Director of Nursing received 1:1 education by Corporate Clinical Nurse to ensure that enough nurses are in the facility to administer medication per MD orders. Expectation is if there is no one to take the medication cart the expectation is the Director of Nursing and/or Unit Manager will come to the facility to administer medication(s). Director of Nursing and/or Regional Clinical Nurse completed re-education with licensed nurses, medication aides, including agency, related to timely documentation of medication/treatment administration records. This included, notification of the Medical Director, Director of Nursing and Executive Director if medication or treatments were not completed timely. Any licensed nurse, including agency who has not received this education by 12/10/21, they will not be able to work until education completed.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.<br>The director of nursing and/or unit managers will be reviewing current resident medication/treatment records, for previous 24 hours, at the facility clinical AM meeting, 5 x week for 4 weeks, then 3 x week for 4 weeks, to ensure that residents are receiving their medication/treatments as ordered by their attending physician. | |

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| F 760 | Continued From page 59<br>during the assessment period.<br><br>The care plan last revised on 5/9/21 identified diabetes mellitus and uncontrolled blood sugar levels with the goal Resident #12 would have an A1C (a percentage of blood glucose readings over a period of 3 months) be below 6. Interventions included administer hypoglycemic agents and obtain blood glucose levels as ordered.<br><br>Review of physician orders for insulin revealed Resident #12 was to receive aspart inject subcutaneously per sliding scale started on 3/24/21 and detemir inject 30 units subcutaneously every morning started on 6/24/21 for the diagnosis of diabetes mellitus.<br><br>A review of Resident #12's Medication Administration Record (MAR) revealed on 10/10/21 the letter N was documented for the times of 7:30 AM and 11:30 AM under the administration of sliding scale aspart insulin with no blood glucose readings documented. The next scheduled blood glucose reading for Resident #12 was done on 10/10/21 at 4:30 PM with a level of 301 and 6 units of aspart insulin was provided per sliding scale of 301 to 350. The letter N was also documented under the administration of detemir insulin inject 30 units subcutaneously scheduled at 8:00 AM.<br><br>A second review of Resident #12's MAR revealed on 10/24/21 the letter N was documented for the times of 7:30 AM and 11:30 AM under the | F 760 | The director of nursing will complete a summary of these audit results and present at the monthly Quality Assurance Performance Improvement meeting, to ensure continued compliance.<br><br># 5 - Completion date: 12/10/2021 | |

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administration of sliding scale aspart insulin with no blood glucose readings documented. The next scheduled blood glucose reading for Resident #12 was done at 4:30 PM with a level of 260 and 4 units of aspart insulin was provided per sliding scale of 251 to 300. The letter N was also documented under the administration of detemir insulin inject 30 units subcutaneously scheduled at 8:00 AM.

An interview was conducted on 10/28/21 at 5:25 PM with Nurse #1. Nurse #1 revealed on 10/10/21 and 10/24/21 she worked by herself on a unit with a 2-nurse assignment and was the only nurse till approximately 3 PM on both days. Nurse #1 revealed she was unable to administer all medications to residents on the second nurse assignment and had not checked blood glucose readings or administered insulin. Nurse #1 revealed she notified the Director of Nursing (DON) there was no nurse assigned to complete medication administration for the second nurse assignment on 10/10/21 and 10/24/21 and it was after 3:00 PM before a second nurse arrived to help.

An interview was conducted on 11/4/21 at 10:32 AM with the MD. The MD revealed blood glucose levels needed to be monitored closely for the administration of insulin. The MD revealed if blood glucose levels were not taken, and insulin doses were missed he considered as a significant medication error for a diabetic. The MD expected physician orders to be followed, and when missed, for the nurse or DON to contact him or the Nurse Practitioner.

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3.Resident #13 was admitted to the facility on 4/9/19 with diagnoses of type 2 diabetes mellitus and chronic obstruction pulmonary disease.

Review of physician orders for insulin revealed Resident #13 was to receive aspart inject 25 units subcutaneously before meals started on 6/29/21 and detemir inject 30 units subcutaneously twice a day started on 5/27/21 for diabetes mellitus.

Review of the quarterly MDS dated 8/24/21 assessed Resident #13's cognition as being intact. The medication review of the MDS revealed insulin injections were administered for 7 days during the assessment period.

The care plan last reviewed on 9/6/21 identified risk related to the diagnosis of diabetes mellitus with the goal Resident #13 would not experience hypo and/or hyperglycemia through the next review. Interventions included administer insulin as ordered.

A review of MAR for Resident #13 revealed on 10/10/21 the letter N was documented under the administration of insulin aspart inject 25 units scheduled at 7:30 AM and no documentation under the 11:30 AM administration time. The next scheduled dose of insulin aspart was administered at 4:30 PM. The letter N was also documented under the insulin detemir inject 30 units scheduled at 8:00 AM with no blood glucose reading documented. The next scheduled dose of insulin detemir was administered at 8:00 PM with

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a blood glucose reading of 214.

A second review of the MAR for Resident #13 revealed on 10/24/21 the letter N was documented under the administration of insulin aspart inject 25 units scheduled at 7:30 AM and 11:30 AM. The next scheduled dose was administered at 4:30 PM. The letter N was also documented under the scheduled 8:00 AM dose of insulin detemir. The next dose was administered at 8:00 PM with a blood glucose reading of 263.

An interview was conducted on 10/28/21 at 5:25 PM with Nurse #1. Nurse #1 revealed on 10/10/21 and 10/24/21 she worked by herself on a unit with a 2-nurse assignment and was the only nurse till approximately 3 to 4 PM on both days. Nurse #1 revealed she was unable to administer all medications to residents on the second nurse assignment and had not checked blood glucose readings or administered insulin. Nurse #1 revealed she notified the Director of Nursing (DON) there was no nurse assigned to complete medication administration for the second nurse assignment on 10/10/21 and 10/24/21 and it was after 3:00 PM before a second nurse arrived to help.

An interview was conducted on 11/4/21 at 10:32 AM with the MD. The MD revealed blood glucose levels needed to be monitored closely for the administration of insulin. The MD revealed if blood glucose levels were not taken, and insulin doses were missed he considered as a significant error for a diabetic. The MD expected physician

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orders to be followed, and when missed, for the nurse or DON to contact him or the Nurse Practitioner.

During an interview on 10/29/21 at 4:30 PM the Director of Nursing (DON) revealed she was unaware residents did not receive their scheduled medications on 10/10/21 or 10/24/21. The DON revealed she was not aware there was no nurse on to cover an assignment on 10/10/21 and explained typically if a nurse shift was not covered, she came in to cover but was out of town. On 10/24/21 the DON revealed she was aware there was not a nurse to cover the second assignment on the unit with Nurse #1 and stated with the number of residents on the unit she would not expect one nurse could complete a medication administration for all the residents by herself. The DON revealed she was also out of town on 10/24/21 but kept in contact with Nurse #1 on 10/24/21 to let her know the second shift nurse would be coming in earlier to help.

During an interview on 10/29/21 at 1:52 PM the Interim Administrator (IA) revealed she was not made aware residents did not receive medications on 10/10/21 and 10/24/21. The IA explained the facility continued to have nursing staff shortages, but she did not know the shortage specifically related to residents missing their medications. The IA revealed during their Interdisciplinary Team Meetings there had been no discussion about residents who did not receive their medications on 10/10/21 and 10/24/21 because a lack of nurse staff to administer medication. The IA stated on the dates there was no nurse to cover an assignment and she

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|---|---|---|---|
| | 345489 | A. BUILDING _____ B. WING _____ | C 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SATURN NURSING AND REHABILITATION CENTER | 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 760 | Continued From page 64<br>believed in the chain of command and the nurse should inform their superior or the DON if medications were not given and would expect the DON to notify her. | F 760 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to label and date leftover food and residents' personal food items stored ready for use in 3 of 3 nourishment room refrigerators (South Hall, North Hall and West Hall).<br><br>Findings included:<br><br>During a tour of the South Hall nourishment room on 10/28/2021 at 4:24 PM with the interim Food | F 812 | F-812 Food Storage<br><br># 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>No Resident was named.<br>Food Service Manager discarded unlabeled, undated items from the nourishment rooms (South, North, West), | 12/10/21 |

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| F 812 | Continued From page 65<br>Service Manager (FSM), observations were made of an unlabeled, undated fast-food shake, an unlabeled smoothie drink, and an unlabeled water container, soft drink, and nutritional supplement in the freezer. An opened, unlabeled container of mayonnaise was observed in the refrigerator. An unlabeled, undated lunch bag containing an additional 3 unlabeled, undated plastic-wear containers were also observed in the refrigerator.<br><br>During a tour of the North Hall nourishment room on 10/28/2021 at 4:31 PM with the interim FSM, observation was made of an opened, unlabeled bag of bread in the refrigerator and an unlabeled slab of spareribs in the freezer.<br><br>During a tour of the West Hall nourishment room on 10/28/2021 at 4:38 PM with the interim FSM, observations were made of an unsealed, unlabeled bag of chicken strips, and an unlabeled container of ice cream in the freezer. Two containers of opened unlabeled salad dressing were observed in the refrigerator.<br><br>Interview with the interim FSM on 10/28/2021 at 4:42 PM revealed the food items in the resident nourishment room refrigerators should have been labeled and dated.<br><br>Interview with the Dietary Manager (DM) on 10/29/2021 at 12:40 PM revealed he was responsible for maintaining the refrigerators in the resident nourishment rooms and all staff were responsible for labeling and dating food brought in from outside the facility. The DM stated he was working excessively long hours in the kitchen and did not get to his responsibilities in the resident nourishment rooms. | F 812 | on 10/29/21.<br><br># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected.<br>Food Service Manager did complete observation rounds to ensure that the facility nourishment rooms did not have any other items, unlabeled/undated, 10/29/21<br><br># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br>Facility Nourishment rooms will be stocked daily by dietary department and open items, should be labeled, dated, and resident name (if applicable). On the 3rd day items will be considered expired and will be discarded. Nursing Staff will ensure that any of the residents' opened food items are labeled, dated, and resident name is present. If the resident has not used the item by the 3rd day it will be discarded. Facility Social Worker and Activities Director conducted a meeting with the facility resident council to re-educated on the proper storage of any food items stored in the facility nourishment rooms. This training was completed on 12/10/21<br>All dining staff and nursing staff, including agency received education by Dietary Manager and Regional Clinical Nurse regarding proper labeling, storage, and discarding expired food items, on | |

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| F 812 | Continued From page 66<br>The Administrator stated in an interview on 10/29/2021 at 2:10 PM that the dietary department should be checking the nourishment room refrigerators daily for cleanliness, food labeling, dating, and temperature. | F 812 | 11/11/2021.<br><br># - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Executive Director and/or Dietary Manager will inspect the facility Nourishment Rooms, including refrigerators and food storage areas to ensure that food items has been labeled with an open date, resident name, and has been discarded timely. These audits will be completed 2 times a week for 2 weeks, then weekly for 2 weeks. An audit tool titled “Food Storage” was developed to record these results.<br>Executive director and/or dietary Manager will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement Committee meetings times three months where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>#5 – Compliance Date: 12/10/2021 | |